Leingang
CHIROPRACTIC & WELLNESS

1 **How did you hear of us?**_____ **If referred, by whom?**_____

Patient Information

Last Name:_____First:_____ M.I. _____

Address:_____ City:_____

State:_____ Zip Code:_____ Gender: M / F DOB: _____ Age: _____

Siblings #: _____ SSN #: _____

Phone #:_____ Cell #: _____

Fathers name:_____ DOB: _____ Employer:_____

Mothers name:_____ DOB: _____ Employer:_____

E-mail Address:_____ Ok to contact by email?_____

Has your child received chiropractic care in the past? YES / NO When? _____

If yes, please give name of the Chiropractor:_____

Please describe the reason for previous care:_____

Has any adult in your family seen a Chiropractor? YES / NO Has any child in your family seen a Chiropractor? YES / NO

Please provide a copy of your child's Insurance card(s)

Insurance Company:_____ Insurance ID#_____

Insured Name: _____ Insured Date of Birth: _____

2

Patient Condition

Reason(s) for visit:_____

Is this condition due to an accident? YES / NO ☐Auto ☐Home ☐Other Date:_____

When did the symptoms appear? _____ Is this condition getting worse? YES / NO

How often does your child has this problem? _____ Is it constant or does it come and go? _____

Does it interfere with your: ☐Sleep ☐Daily Routine ☐Recreation ☐ Sports ☐ School ☐None

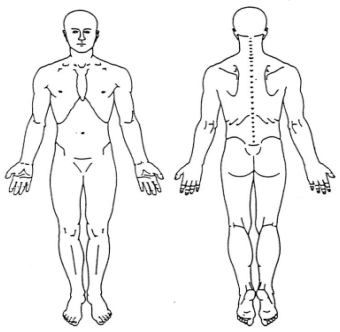
Activities or movements that are difficult / painful to perform for your child:

Lying Down ☐ Bending ☐ Walking ☐ Standing ☐ Sitting ☐

What treatment has your child already received for this condition? ☐ Medications (Prescription or over the counter) ☐ Physical Therapy ☐ Surgery ☐Chiropractic Care ☐Stretches ☐ Ice/Heat ☐Other ☐None

Name of other doctor(s) who has/have treated your child for this condition:_____

Body Diagram Instructions: On the body diagram below, please indicate where your child's pain is located at the present time. Please do not indicate areas of pain that are not related to your child's present injury or condition.



Please rate your child's pain: 0(no pain) to 10(worst pain)_____

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3 Personal Health History

Is your child currently under the care of a Healthcare Provider or any other Doctor? YES / NO
If yes, for what condition(s): _____
_____

Place an "X" to indicate if your child has had any of the following:

Headaches	Irritable Bowel Syndrome	Difficulty Walking	Frequent Infections
Sinus Problems	Liver Trouble/Hepatitis	Skin Problems	Ankle/Foot Pain
Dizziness	Kidney Problems	Easy Bruising	Sciatica
Neck Pain	Difficulty Urinating	Anxiety	Scoliosis
Thyroid Problems	Prostate Problems	Depression	Hip/Leg Problems
Shoulder/Arm Problems	Menstrual Problems	Unexplained Fatigue	Fainting
Ear Problems	Pelvic Pain	Jaw Problems	ADD/ADHD
Asthma	Heart Problems	Arthritis	Seizures/Convulsions
Throat Problems	Poor Circulation	Chronic Cough/Cold	Orthopedic Issues
Difficulty Breathing	Digestive Issues	Osteoporosis	Growing Pains
Mid Back/Rib Pain	Colon Trouble	Diabetes Type I or II	Muscle Pain
Chest Pain	Diverticulitis	High Blood Pressure	Ruptures/Hernia
Wrist/Elbow/Hand Pain	Stroke	Cancer	Constipation
Low Back Pain	Knee Pain	Glasses/Contacts	Anemia
Joint Problems	Poor Posture	Scoliosis	Allergies

Has your child sustained an injury playing organized sports? _____
_____

Other health issues, please specify: _____
_____

Injuries / Surgeries your child has had:	Description	Date/Year
Falls/Injuries		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Car Accidents		

4 Family History

Relation	Living	Deceased	Age (now or at death)	Serious Illnesses / Cause of Death
Mother				
Father				
Sister(s)				
Brother(s)				

5 Social History

How often does your child exercise? _____
How would you rate your child's diet? _____
Is your child satisfied with his/her weight? YES / NO
Has your child gained or lost 10lbs in the past 6 months without wanting to? YES / NO
Is your child on any special diet? YES / NO If yes, please describe: _____
How many 8 oz glasses of water does your child drink a day? _____

OVER→

6 Birth History

Third Trimester Presentation: Vertex _____ Breech _____ Transverse _____ Face/Brow _____
Type of Birth: Normal Vaginal_____ Forceps_____ Cesarean_____ Suction Cap or Vacuum_____
Location: Birthing center _____ Home _____ Hospital _____

Problems during pregnancy: _____
Problems during labor/delivery: _____

Apgar Scores: _____Was there presence at birth of Jaundice (yellow): _____ Cyanosis (Blue): _____
Congenital Anomalies/Defects? _____ If yes please explain? _____

Infant feeding: Breast_____Bottle _____ If bottle which formula? _____
Number of hours sleeping per night: _____ Quality of sleep: Good _____ Fair _____ Poor _____

Obstetrician/Midwife:_____ Pediatrician/Family MD:_____
Date of Last Visit:_____ Purpose:_____
Immunization History:_____
Number of Antibiotics Your Child Has Taken: During the Past Six Months_____ During His/Her Lifetime:_____

7 Review

How would you rate your child's general health? (Mark an "X" where you feel it is)
Poor I----------I Excellent

What are your child's health goals? _____
_____
_____

8 AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and it's doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).
I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided.

Signature Date Relation to patient

9 AUTHORIZATION FOR ACUPUNCTURE LASER/NEEDLES

I hereby authorize the Doctor to work with my condition through the use of acupuncture to my body, as he or she deems appropriate. The Doctor will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis. If the Doctor does accept my case, it does not guarantee nor does it imply a guarantee of being able to cure or prevent any condition illness or injury. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

Patient's signature Date Guardian or Parent's Signature

OVER→

AUTHORIZATION FOR CHIROPRACTIC CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I attest that all the answers I have given are correct, to the best of my knowledge, and I agree to continue with my Chiropractic evaluation at Leingang Chiropractic and Wellness at this time. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Patient's signature Date Guardian or Parent's Signature

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

An **adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, _____have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient's signature_____Date_____Witness_____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient Name(Print): _____ Relationship to Patient: _____

Signature:_____ Date: _____